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| | | FOR OHF USE | | | | | |
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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---------------------------------------|---------------------------------------|---|-------------------------------------|--------------------------------|--------------------------------|--------------------------------------|---------------------------------|---------------------------------|---|--------------------------------------|--|--|--|--|--|--|--|--------------------------------|--|--|--------------------------------------|--|--|--------------------------------------|-----------------------------|--|---------------|-----------------------------|------------------------------|--|---|
| <p>I. IDPH Facility ID Number: <u>0037424</u></p> <p>Facility Name: <u>FIRESIDE HOUSE OF CENTRALIA</u></p> <p>Address: <u>1030 McCORD</u> <u>CENTRALIA</u> <u>62801</u> Number City Zip Code</p> <p>County: <u>MARION</u></p> <p>Telephone Number: <u>(618) 532-1834</u> Fax # <u>(618) 532-1308</u></p> <p>IDPA ID Number: <u>431588535006</u></p> <p>Date of Initial License for Current Owners: <u>12/05/91</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mike Gearheart</u> Telephone Number: <u>(678) 296-4486</u></p> | <input type="checkbox"/> VOLUNTARY, NON-PROFIT | <input type="checkbox"/> PROPRIETARY | <input type="checkbox"/> GOVERNMENTAL | <input type="checkbox"/> Charitable Corp. | <input type="checkbox"/> Individual | <input type="checkbox"/> State | <input type="checkbox"/> Trust | <input type="checkbox"/> Partnership | <input type="checkbox"/> County | IRS Exemption Code _____ | <input checked="" type="checkbox"/> Corporation | <input type="checkbox"/> Other _____ | | <input type="checkbox"/> "Sub-S" Corp. | | | <input type="checkbox"/> Limited Liability Co. | | | <input type="checkbox"/> Trust | | | <input type="checkbox"/> Other _____ | | <p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>MAY 1, 1999</u> to <u>APRIL 30, 2000</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1165 678 1297 824" rowspan="2">Officer or Administrator of Provider</td> <td data-bbox="1297 678 1944 743">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1297 743 1944 808">(Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td data-bbox="1165 824 1297 1036" rowspan="4">Paid Preparer</td> <td data-bbox="1297 824 1944 889">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1297 889 1944 954">(Print Name and Title) _____</td> </tr> <tr> <td data-bbox="1297 954 1944 1019">(Firm Name & Address) <u>HEALTHPRIME, 950 North Point Pkwy. St. 100 - Alpharetta</u></td> </tr> <tr> <td data-bbox="1297 1019 1944 1036">(Telephone) <u>(770) 619-0866</u> Fax # <u>(770) 619-0262</u></td> </tr> </table> <p align="center"> MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p> | Officer or Administrator of Provider | (Signed) _____ (Date) _____ | (Type or Print Name) _____ (Title) _____ | Paid Preparer | (Signed) _____ (Date) _____ | (Print Name and Title) _____ | (Firm Name & Address) <u>HEALTHPRIME, 950 North Point Pkwy. St. 100 - Alpharetta</u> | (Telephone) <u>(770) 619-0866</u> Fax # <u>(770) 619-0262</u> |
| <input type="checkbox"/> VOLUNTARY, NON-PROFIT | <input type="checkbox"/> PROPRIETARY | <input type="checkbox"/> GOVERNMENTAL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Charitable Corp. | <input type="checkbox"/> Individual | <input type="checkbox"/> State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Trust | <input type="checkbox"/> Partnership | <input type="checkbox"/> County | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IRS Exemption Code _____ | <input checked="" type="checkbox"/> Corporation | <input type="checkbox"/> Other _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> "Sub-S" Corp. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> Limited Liability Co. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> Trust | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> Other _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Officer or Administrator of Provider | (Signed) _____ (Date) _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | (Type or Print Name) _____ (Title) _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Paid Preparer | (Signed) _____ (Date) _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | (Print Name and Title) _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | (Firm Name & Address) <u>HEALTHPRIME, 950 North Point Pkwy. St. 100 - Alpharetta</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | (Telephone) <u>(770) 619-0866</u> Fax # <u>(770) 619-0262</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA# 0037424 Report Period Beginning: MAY 1, 1999 Ending: APRIL 30, 2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

| | 1 | 2 | 3 | 4 | |
|---|--|-----------------------------|---------------------------------|--|---|
| | Beds at Beginning of Report Period | Licensure Level of Care | Beds at End of Report Period | Licensed Bed Days During Report Period | |
| 1 | <u>24</u> | Skilled (SNF) | <u>24</u> | <u>8,784</u> | 1 |
| 2 | | Skilled Pediatric (SNF/PED) | | | 2 |
| 3 | <u>74</u> | Intermediate (ICF) | <u>74</u> | <u>27,084</u> | 3 |
| 4 | | Intermediate/DD | | | 4 |
| 5 | | Sheltered Care (SC) | | | 5 |
| 6 | | ICF/DD 16 or Less | | | 6 |
| 7 | <u>98</u> | TOTALS | <u>98</u> | <u>35,868</u> | 7 |

B. Census-For the entire report period.

| | 1 | 2 | 3 | 4 | 5 | |
|----|---------------|---|--------------|--------------|---------------|----|
| | Level of Care | Patient Days by Level of Care and Primary Source of Payment | | | | |
| | | Public Aid Recipient | Private Pay | Other | Total | |
| 8 | SNF | <u>1,700</u> | <u>105</u> | <u>4,579</u> | <u>6,384</u> | 8 |
| 9 | SNF/PED | | | | | 9 |
| 10 | ICF | <u>18,863</u> | <u>4,009</u> | <u>282</u> | <u>23,154</u> | 10 |
| 11 | ICF/DD | | | | | 11 |
| 12 | SC | | | | | 12 |
| 13 | DD 16 OR LESS | | | | | 13 |
| 14 | TOTALS | <u>20,563</u> | <u>4,114</u> | <u>4,861</u> | <u>29,538</u> | 14 |

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 82.35%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)MEALSF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 12/05/91

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 10/16/91 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 24 and days of care provided 4,579Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: APRIL 30 Fiscal Year: APRIL 30

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0037424 Report Period Beginning: MAY 1, 1999 Ending: APRIL 30, 2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

| | Operating Expenses | Costs Per General Ledger | | | | Reclass-ification 5 | Reclassified Total 6 | Adjust-ments 7 | Adjusted Total 8 | FOR OHF USE ONLY | |
|-----|--|--------------------------|---------------|------------|------------|------------------------|----------------------------|-------------------|------------------------|------------------|-----|
| | | Salary/Wage 1 | Supplies 2 | Other 3 | Total 4 | | | | | 9 | 10 |
| | A. General Services | | | | | | | | | | |
| 1 | Dietary | 108,252 | 10,592 | 13,342 | 132,186 | | 132,186 | | 132,186 | | 1 |
| 2 | Food Purchase | | 131,091 | | 131,091 | (1,116) | 129,975 | (1,262) | 128,713 | | 2 |
| 3 | Housekeeping | 65,852 | 12,277 | | 78,129 | | 78,129 | | 78,129 | | 3 |
| 4 | Laundry | 33,691 | 7,605 | 3,458 | 44,754 | | 44,754 | | 44,754 | | 4 |
| 5 | Heat and Other Utilities | | | 84,574 | 84,574 | | 84,574 | (325) | 84,249 | | 5 |
| 6 | Maintenance | 19,353 | 1,176 | 18,190 | 38,719 | | 38,719 | | 38,719 | | 6 |
| 7 | Other (specify):* WASTE DISPOSAL | | | 6,770 | 6,770 | | 6,770 | | 6,770 | | 7 |
| 8 | TOTAL General Services | 227,148 | 162,741 | 126,334 | 516,223 | (1,116) | 515,107 | (1,587) | 513,520 | | 8 |
| | B. Health Care and Programs | | | | | | | | | | |
| 9 | Medical Director | | | 4,800 | 4,800 | | 4,800 | | 4,800 | | 9 |
| 10 | Nursing and Medical Records | 751,391 | 50,063 | 76,565 | 878,019 | | 878,019 | | 878,019 | | 10 |
| 10a | Therapy | 15,301 | 2,330 | 199,336 | 216,967 | | 216,967 | | 216,967 | | 10a |
| 11 | Activities | 23,580 | 797 | 2,513 | 26,890 | | 26,890 | | 26,890 | | 11 |
| 12 | Social Services | 16,442 | | 2,592 | 19,034 | | 19,034 | | 19,034 | | 12 |
| 13 | Nurse Aide Training | 10,283 | | | 10,283 | | 10,283 | | 10,283 | | 13 |
| 14 | Program Transportation | | | | | | | | | | 14 |
| 15 | Other (specify):* | | | | | | | | | | 15 |
| 16 | TOTAL Health Care and Programs | 816,997 | 53,190 | 285,806 | 1,155,993 | | 1,155,993 | | 1,155,993 | | 16 |
| | C. General Administration | | | | | | | | | | |
| 17 | Administrative | 45,908 | | 463,730 | 509,638 | | 509,638 | (362,989) | 146,649 | | 17 |
| 18 | Directors Fees | | | | | | | | | | 18 |
| 19 | Professional Services | | | 429 | 429 | | 429 | 12,883 | 13,312 | | 19 |
| 20 | Dues, Fees, Subscriptions & Promotions | | | 15,594 | 15,594 | | 15,594 | (4,466) | 11,128 | | 20 |
| 21 | Clerical & General Office Expenses | 16,664 | 9,318 | 21,275 | 47,257 | | 47,257 | 28,546 | 75,803 | | 21 |
| 22 | Employee Benefits & Payroll Taxes | | | 197,516 | 197,516 | | 197,516 | 14,743 | 212,259 | | 22 |
| 23 | Inservice Training & Education | | | 1,618 | 1,618 | | 1,618 | 64 | 1,682 | | 23 |
| 24 | Travel and Seminar | | | 3,189 | 3,189 | | 3,189 | 18,529 | 21,718 | | 24 |
| 25 | Other Admin. Staff Transportation | | | | | | | | | | 25 |
| 26 | Insurance-Prop.Liab.Malpractice | | | 9,759 | 9,759 | | 9,759 | 39,138 | 48,897 | | 26 |
| 27 | Other (specify):* Bad Debts | | | 652 | 652 | | 652 | (652) | | | 27 |
| 28 | TOTAL General Administration | 62,572 | 9,318 | 713,762 | 785,652 | | 785,652 | (254,204) | 531,448 | | 28 |
| 29 | TOTAL Operating Expense (sum of lines 8, 16 & 28) | 1,106,717 | 225,249 | 1,125,902 | 2,457,868 | (1,116) | 2,456,752 | (255,791) | 2,200,961 | | 29 |

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

| | Capital Expense | Cost Per General Ledger | | | | Reclass-ification 5 | Reclassified Total 6 | Adjust-ments 7 | Adjusted Total 8 | FOR OHF USE ONLY | | |
|----|---|-------------------------|---------------|------------|------------|------------------------|----------------------------|-------------------|------------------------|------------------|----|----|
| | | Salary/Wage 1 | Supplies 2 | Other 3 | Total 4 | | | | | 9 | 10 | |
| | D. Ownership | | | | | | | | | | | |
| 30 | Depreciation | | | 1,251 | 1,251 | | 1,251 | 129,096 | 130,347 | | | 30 |
| 31 | Amortization of Pre-Op. & Org. | | | | | | | 3,083 | 3,083 | | | 31 |
| 32 | Interest | | | 34,915 | 34,915 | | 34,915 | 261,069 | 295,984 | | | 32 |
| 33 | Real Estate Taxes | | | | | | | 43,933 | 43,933 | | | 33 |
| 34 | Rent-Facility & Grounds | | | 374,867 | 374,867 | | 374,867 | (366,577) | 8,290 | | | 34 |
| 35 | Rent-Equipment & Vehicles | | | 2,865 | 2,865 | | 2,865 | 1,866 | 4,731 | | | 35 |
| 36 | Other (specify):* | | | | | | | | | | | 36 |
| 37 | TOTAL Ownership | | | 413,898 | 413,898 | | 413,898 | 72,470 | 486,368 | | | 37 |
| | Ancillary Expense | | | | | | | | | | | |
| | E. Special Cost Centers | | | | | | | | | | | |
| 38 | Medically Necessary Transportation | | | | | | | | | | | 38 |
| 39 | Ancillary Service Centers | | 100,758 | 7,598 | 108,356 | | 108,356 | | 108,356 | | | 39 |
| 40 | Barber and Beauty Shops | | | | | | | | | | | 40 |
| 41 | Coffee and Gift Shops | | | | | 1,116 | 1,116 | (1,116) | | | | 41 |
| 42 | Provider Participation Fee | | | 53,655 | 53,655 | | 53,655 | | 53,655 | | | 42 |
| 43 | Other (specify):* Lab/Xray | | | 6,874 | 6,874 | | 6,874 | | 6,874 | | | 43 |
| 44 | TOTAL Special Cost Centers | | 100,758 | 68,127 | 168,885 | 1,116 | 170,001 | (1,116) | 168,885 | | | 44 |
| 45 | GRAND TOTAL COST (sum of lines 29, 37 & 44) | 1,106,717 | 326,007 | 1,607,927 | 3,040,651 | | 3,040,651 | (184,437) | 2,856,214 | | | 45 |

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

| | 1 | 2 | 3 | |
|---|------------|--------|---------|----|
| | Amount | Refer- | OHF USE | |
| NON-ALLOWABLE EXPENSES | | ence | ONLY | |
| 1 Day Care | \$ | | \$ | 1 |
| 2 Other Care for Outpatients | | | | 2 |
| 3 Governmental Sponsored Special Programs | | | | 3 |
| 4 Non-Patient Meals | (306) | 2 | | 4 |
| 5 Telephone, TV & Radio in Resident Rooms | (325) | 5 | | 5 |
| 6 Rented Facility Space | | | | 6 |
| 7 Sale of Supplies to Non-Patients | | | | 7 |
| 8 Laundry for Non-Patients | | | | 8 |
| 9 Non-Straightline Depreciation | | | | 9 |
| 10 Interest and Other Investment Income | (19) | 32 | | 10 |
| 11 Discounts, Allowances, Rebates & Refunds | | | | 11 |
| 12 Non-Working Officer's or Owner's Salary | | | | 12 |
| 13 Sales Tax | (956) | 2 | | 13 |
| 14 Non-Care Related Interest | | | | 14 |
| 15 Non-Care Related Owner's Transactions | | | | 15 |
| 16 Personal Expenses (Including Transportation) | | | | 16 |
| 17 Non-Care Related Fees | | | | 17 |
| 18 Fines and Penalties | (408) | 21 | | 18 |
| 19 Entertainment | | | | 19 |
| 20 Contributions | | | | 20 |
| 21 Owner or Key-Man Insurance | | | | 21 |
| 22 Special Legal Fees & Legal Retainers | | | | 22 |
| 23 Malpractice Insurance for Individuals | | | | 23 |
| 24 Bad Debt | (652) | 27 | | 24 |
| 25 Fund Raising, Advertising and Promotional | (4,698) | 20 | | 25 |
| 26 Income Taxes and Illinois Personal Property Replacement Tax | | | | 26 |
| 27 Nurse Aide Training for Non-Employees | | | | 27 |
| 28 Yellow Page Advertising | | | | 28 |
| 29 Other-Attach Schedule vending/other rev | (1,538) | | | 29 |
| 30 SUBTOTAL (A): (Sum of lines 1-29) | \$ (8,902) | | \$ | 30 |

| OHF USE ONLY | | | | | | |
|--------------|--|----|----|----|----|--|
| 48 | | 49 | 50 | 51 | 52 | |

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

| | 1 | 2 | |
|---|--------------|-----------|----|
| | Amount | Reference | |
| 31 Non-Paid Workers-Attach Schedule* | \$ | | 31 |
| 32 Donated Goods-Attach Schedule* | | | 32 |
| 33 Amortization of Organization & Pre-Operating Expense | | | 33 |
| 34 Adjustments for Related Organization Costs (Schedule VII) | (175,535) | HOME O | 34 |
| 35 Other- Attach Schedule | | | 35 |
| 36 SUBTOTAL (B): (sum of lines 31-35) | \$ (175,535) | | 36 |
| (sum of SUBTOTALS | | | |
| 37 TOTAL ADJUSTMENTS (A) and (B)) | \$ (184,437) | | 37 |

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
 (See instructions.)

| | 1 | 2 | 3 | 4 | |
|------------------------------------|-----|----|--------|-----------|----|
| | Yes | No | Amount | Reference | |
| 38 Medically Necessary Transport. | | | \$ | | 38 |
| 39 | | | | | 39 |
| 40 Gift and Coffee Shops | | | | | 40 |
| 41 Barber and Beauty Shops | | | | | 41 |
| 42 Laboratory and Radiology | | | | | 42 |
| 43 Prescription Drugs | | | | | 43 |
| 44 Exceptional Care Program | | | | | 44 |
| 45 Other-Attach Schedule | | | | | 45 |
| 46 Other-Attach Schedule | | | | | 46 |
| 47 TOTAL (C): (sum of lines 38-46) | | | \$ | | 47 |

| NON-ALLOWABLE EXPENSES | | Amount | Sch. V Line Reference |
|------------------------|--------------------------|---------|-----------------------|
| 1 | | \$ | 1 |
| 2 | | | 2 |
| 3 | | | 3 |
| 4 | | | 4 |
| 5 | | | 5 |
| 6 | | | 6 |
| 7 | | | 7 |
| 8 | | | 8 |
| 9 | | | 9 |
| 10 | | | 10 |
| 11 | | | 11 |
| 12 | Vending Revenue | (1,116) | 41 |
| 13 | Other Revenue -HPSI Fees | (422) | 20 |
| 14 | | | 14 |
| 15 | | | 15 |
| 16 | | | 16 |
| 17 | | | 17 |
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| 87 | | | 87 |
| 88 | | | 88 |
| 89 | | | 89 |
| 90 | Total | (1,538) | 90 |

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA# 0037424

Report Period Beginning:

MAY 1, 1999

Ending:

APRIL 30, 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

| | Operating Expenses | PAGES 5 & 5A | PAGE 6 | PAGE 6A | PAGE 6B | PAGE 6C | PAGE 6D | PAGE 6E | PAGE 6F | PAGE 6G | PAGE 6H | PAGE 6I | SUMMARY TOTALS (to Sch V, col.7) | |
|-----|---|-----------------|------------------|---------------|------------|------------|------------|------------|------------|------------|------------|------------|--|-----------|
| | A. General Services | | | | | | | | | | | | | |
| 1 | Dietary | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| 2 | Food Purchase | (1,262) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (1,262) | 2 |
| 3 | Housekeeping | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| 4 | Laundry | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 |
| 5 | Heat and Other Utilities | (325) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (325) | 5 |
| 6 | Maintenance | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 |
| 7 | Other (specify):* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 7 |
| 8 | TOTAL General Services | (1,587) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (1,587) | 8 |
| | B. Health Care and Programs | | | | | | | | | | | | | |
| 9 | Medical Director | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9 |
| 10 | Nursing and Medical Records | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 10 |
| 10a | Therapy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 10a |
| 11 | Activities | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 11 |
| 12 | Social Services | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 12 |
| 13 | Nurse Aide Training | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 13 |
| 14 | Program Transportation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 14 |
| 15 | Other (specify):* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 15 |
| 16 | TOTAL Health Care and Programs | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 16 |
| | C. General Administration | | | | | | | | | | | | | |
| 17 | Administrative | 0 | (368,389) | 5,400 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (362,989) | 17 |
| 18 | Directors Fees | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 18 |
| 19 | Professional Services | 0 | 12,883 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 12,883 | 19 |
| 20 | Fees, Subscriptions & Promotions | (5,120) | 654 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (4,466) | 20 |
| 21 | Clerical & General Office Expenses | (408) | 28,954 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 28,546 | 21 |
| 22 | Employee Benefits & Payroll Taxes | 0 | 14,743 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 14,743 | 22 |
| 23 | Inservice Training & Education | 0 | 64 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 64 | 23 |
| 24 | Travel and Seminar | 0 | 18,529 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 18,529 | 24 |
| 25 | Other Admin. Staff Transportation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 25 |
| 26 | Insurance-Prop.Liab.Malpractice | 0 | 125 | 39,013 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 39,138 | 26 |
| 27 | Other (specify):* | (652) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (652) | 27 |
| 28 | TOTAL General Administration | (6,180) | (292,437) | 44,413 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (254,204) | 28 |
| 29 | TOTAL Operating Expense (sum of lines 8,16 & 28) | (7,767) | (292,437) | 44,413 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (255,791) | 29 |

Facility Name & ID Number **FIRESIDE HOUSE OF CENTRALIA**# **0037424**Report Period Beginning: **MAY 1, 1999** Ending: **APRIL 30, 2000**

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

| 1 OWNERS | | 2 RELATED NURSING HOMES | | 3 OTHER RELATED BUSINESS ENTITIES | | |
|------------------------------|-------------|-------------------------|------|-----------------------------------|------|------------------|
| Name | Ownership % | Name | City | Name | City | Type of Business |
| See Attached Owner's Listing | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

| 1 | 2 | 3 Cost Per General Ledger | 4 | 5 Cost to Related Organization | 6 | 7 | 8 Difference: | |
|------------|-------|-----------------------------------|------------|--------------------------------|----------------------|--|--|----|
| Schedule V | Line | Item | Amount | Name of Related Organization | Percent of Ownership | Operating Cost of Related Organization | Adjustments for Related Organization Costs (7 minus 4) | |
| 1 | V | 17 Administrative | \$ 463,730 | HUNTER CARE CENTERS | 100.00% | \$ 95,341 | \$ (368,389) | 1 |
| 2 | V | 19 Professional Fees | | | | 12,883 | 12,883 | 2 |
| 3 | V | 20 Dues & Subscriptions | | | | 654 | 654 | 3 |
| 4 | V | 21 Clerical & General Office | | | | 28,954 | 28,954 | 4 |
| 5 | V | 22 Employee Benefits | | | | 14,743 | 14,743 | 5 |
| 6 | V | 23 Education and Training | | | | 64 | 64 | 6 |
| 7 | V | 24 Travel & Seminar | | | | 18,529 | 18,529 | 7 |
| 8 | V | 26 Insurance - Property/Liability | | | | 125 | 125 | 8 |
| 9 | V | 30 Depreciation | | | | 4,511 | 4,511 | 9 |
| 10 | V | 32 Interest | | | | 1,037 | 1,037 | 10 |
| 11 | V | 33 Real Estate Taxes | | | | 56 | 56 | 11 |
| 12 | V | 34 Rent-Leases | | | | 8,290 | 8,290 | 12 |
| 13 | V | 35 Equipment Rental | | | | 1,866 | 1,866 | 13 |
| 14 | Total | | \$ 463,730 | | | \$ 187,053 | \$ * (276,677) | 14 |

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **FIRESIDE HOUSE OF CENTRALIA**# **0037424**Report Period Beginning: **MAY 1, 1999** Ending: **APRIL 30, 2000****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

| 1 | 2 | 3 Cost Per General Ledger | 4 | 5 Cost to Related Organization | 6 | 7 | 8 Difference: | |
|------------|-------|---------------------------------|------------|---------------------------------|----------------------|--|--|----|
| Schedule V | Line | Item | Amount | Name of Related Organization | Percent of Ownership | Operating Cost of Related Organization | Adjustments for Related Organization Costs (7 minus 4) | |
| 15 | V | 17 Administrative | \$ | Hunter Care Center/Fireside L/P | 100.00% | \$ 5,400 | \$ 5,400 | 15 |
| 16 | V | 26 Insurance Property/Liability | | | | 39,013 | 39,013 | 16 |
| 17 | V | 30 Depreciation | | | | 124,585 | 124,585 | 17 |
| 18 | V | 31 Amortization | | | | 3,083 | 3,083 | 18 |
| 19 | V | 32 Interest | | | | 260,051 | 260,051 | 19 |
| 20 | V | 33 Real Estate Taxes | | | | 43,877 | 43,877 | 20 |
| 21 | V | 34 Rent - Facility Grounds | 374,867 | | | | (374,867) | 21 |
| 22 | V | | | | | | | 22 |
| 23 | V | | | | | | | 23 |
| 24 | V | | | | | | | 24 |
| 25 | V | | | | | | | 25 |
| 26 | V | | | | | | | 26 |
| 27 | V | | | | | | | 27 |
| 28 | V | | | | | | | 28 |
| 29 | V | | | | | | | 29 |
| 30 | V | | | | | | | 30 |
| 31 | V | | | | | | | 31 |
| 32 | V | | | | | | | 32 |
| 33 | V | | | | | | | 33 |
| 34 | V | | | | | | | 34 |
| 35 | V | | | | | | | 35 |
| 36 | V | | | | | | | 36 |
| 37 | V | | | | | | | 37 |
| 38 | V | | | | | | | 38 |
| 39 | Total | | \$ 374,867 | | | \$ 476,009 | \$ * 101,142 | 39 |

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7

Facility Name & ID Number **FIRESIDE HOUSE OF CENTRALIA** # **0037424** Report Period Beginning: **MAY 1, 1999** Ending: **APRIL 30, 2000**

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

| | 1 Name | 2 Title | 3 Function | 4 Ownership Interest | 5 Compensation Received From Other Nursing Homes* | 6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week | | 7 Compensation Included in Costs for this Reporting Period** | | 8 Schedule V. Line & Column Reference | |
|----|-----------|------------|---------------|-------------------------|--|--|---------|---|--------|--|----|
| | | | | | | Hours | Percent | Description | Amount | | |
| 1 | N/A | | | | | | | | \$ | | 1 |
| 2 | | | | | | | | | | | 2 |
| 3 | | | | | | | | | | | 3 |
| 4 | | | | | | | | | | | 4 |
| 5 | | | | | | | | | | | 5 |
| 6 | | | | | | | | | | | 6 |
| 7 | | | | | | | | | | | 7 |
| 8 | | | | | | | | | | | 8 |
| 9 | | | | | | | | | | | 9 |
| 10 | | | | | | | | | | | 10 |
| 11 | | | | | | | | | | | 11 |
| 12 | | | | | | | | | | | 12 |
| 13 | | | | | | | | TOTAL | \$ | | 13 |

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA# 0037424Report Period Beginning: MAY 1, 1999Ending: JUL 30, 2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (____) _____

Fax Number (____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

| | 1 Schedule V Line Reference | 2 Item | 3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet) | 4 Total Units | 5 Number of Subunits Being Allocated Among | 6 Total Indirect Cost Being Allocated | 7 Amount of Salary Cost Contained in Column 6 | 8 Facility Units | 9 Allocation (col.8/col.4)x col.6 | |
|----|--------------------------------------|--------------------------------|--|----------------------|---|--|--|----------------------------|---|----|
| 1 | 17 | Administrative | Patient Days | 210,674 | 0 | \$ 679,066 | \$ 678,954 | 29,585 | \$ 95,361 | 1 |
| 2 | 19 | Professional Fees | Patient Days | 210,674 | 0 | 91,760 | | 29,585 | 12,886 | 2 |
| 3 | 20 | Dues & Subscriptions | Patient Days | 210,674 | 0 | 4,661 | | 29,585 | 655 | 3 |
| 4 | 21 | Clerical & General Office | Patient Days | 210,674 | 0 | 206,228 | | 29,585 | 28,961 | 4 |
| 5 | 22 | Employee Benefits | Patient Days | 210,674 | 0 | 105,009 | | 29,585 | 14,746 | 5 |
| 6 | 23 | Education and Training | Patient Days | 210,674 | 0 | 456 | | 29,585 | 64 | 6 |
| 7 | 24 | Travel & Seminar | Patient Days | 210,674 | 0 | 131,972 | | 29,585 | 18,533 | 7 |
| 8 | 26 | Insurance - Property/Liability | Patient Days | 210,674 | 0 | 890 | | 29,585 | 125 | 8 |
| 9 | 30 | Depreciation | Patient Days | 210,674 | 0 | 32,128 | | 29,585 | 4,512 | 9 |
| 10 | 32 | Interest | Patient Days | 210,674 | 0 | 7,387 | | 29,585 | 1,037 | 10 |
| 11 | 33 | Real Estate Taxes | Patient Days | 210,674 | 0 | 399 | | 29,585 | 56 | 11 |
| 12 | 34 | Rent-Leases | Patient Days | 210,674 | 0 | 59,048 | | 29,585 | 8,292 | 12 |
| 13 | 35 | Equipment Rental | Patient Days | 210,674 | 0 | 13,290 | | 29,585 | 1,866 | 13 |
| 14 | | | | | | | | | | 14 |
| 15 | | | | | | | | | | 15 |
| 16 | | | | | | | | | | 16 |
| 17 | | | | | | | | | | 17 |
| 18 | | | | | | | | | | 18 |
| 19 | | | | | | | | | | 19 |
| 20 | | | | | | | | | | 20 |
| 21 | | | | | | | | | | 21 |
| 22 | | | | | | | | | | 22 |
| 23 | | | | | | | | | | 23 |
| 24 | | | | | | | | | | 24 |
| 25 | TOTALS | | | | | \$ 1,332,294 | \$ 678,954 | | \$ 187,094 | 25 |

Facility Name & ID Number **FIRESIDE HOUSE OF CENTRALIA** # **0037424** Report Period Beginning: **MAY 1, 1995** Ending: **APRIL 30, 2000**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

| | 1 Name of Lender | 2 Related** | | 3 Purpose of Loan | 4 Monthly Payment Required | 5 Date of Note | 6 Amount of Note | | 8 Maturity Date | 9 Interest Rate (4 Digits) | 10 Reporting Period Interest Expense | |
|----|-------------------------------------|----------------|----|----------------------|-------------------------------------|----------------------|---------------------|--------------|-----------------------|-------------------------------------|--|----|
| | | YES | NO | | | | Original | Balance | | | | |
| | A. Directly Facility Related | | | | | | | | | | | |
| | Long-Term | | | | | | | | | | | |
| 1 | W.M.F. HUNTOON | | X | FIRST MORTGAGE | \$29,997.66 | 10/91 | \$ 2,957,900 | \$ 2,843,767 | 10/01/60 | 0.0912 | \$ 260,051 | 1 |
| 2 | | | | | | | | | | | | 2 |
| 3 | | | | | | | | | | | | 3 |
| 4 | | | | | | | | | | | | 4 |
| 5 | | | | | | | | | | | | 5 |
| | Working Capital | | | | | | | | | | | |
| 6 | DVI | | X | WORKING CAPITAL | N/A | 4/30/99 | 297,821 | 297,821 | 5/3/00 | Floating | 34,915 | 6 |
| 7 | First America | | x | WORKING CAPITAL | N/A | 12/01/91 | 2,858,548 | PAID IN FULL | 4/30/99 | | | 7 |
| 8 | | | | | | | | | | | | 8 |
| 9 | TOTAL Facility Related | | | | \$29,997.66 | | \$ 6,114,269 | \$ 3,141,588 | | | \$ 294,966 | 9 |
| | B. Non-Facility Related* | | | | | | | | | | | |
| 10 | | | | | | | | | | | | 10 |
| 11 | | | | | | | | | | | | 11 |
| 12 | | | | | | | | | | | | 12 |
| 13 | | | | | | | | | | | | 13 |
| 14 | TOTAL Non-Facility Related | | | | | | \$ | \$ | | | \$ | 14 |
| 15 | TOTALS (line 9+line14) | | | | | | \$ 6,114,269 | \$ 3,141,588 | | | \$ 294,966 | 15 |

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **FIRESIDE HOUSE OF CENTRALIA**# **0037424** Report Period Beginning: **MAY 1, 1999** Ending: **APRIL 30, 2000****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

| | | | |
|--|----|-----------------|---|
| 1. Real Estate Tax accrual used on 1999 report. | \$ | 89,026 | 1 |
| 2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.) | \$ | 46,609 | 2 |
| 3. Under or (over) accrual (line 2 minus line 1). | \$ | (42,417) | 3 |
| 4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.) | \$ | | 4 |
| 5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.) | \$ | 86,294 | 5 |
| 6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.) | \$ | | 6 |
| 7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6. | \$ | 43,877 | 7 |

Real Estate Tax History:

| | | | | | | |
|---|------|---------------|----|----|------------------------------------|----|
| Real Estate Tax Bill for Calendar Year: | 1995 | 37,636 | 8 | | FOR OFF USE ONLY | |
| | 1996 | 40,358 | 9 | | | |
| | 1997 | 43,139 | 10 | 13 | FROM R. E. TAX STATEMENT FOR 1999 | \$ |
| | 1998 | 42,417 | 11 | 14 | PLUS APPEAL COST FROM LINE 5 | \$ |
| | 1999 | 43,877 | 12 | 15 | LESS REFUND FROM LINE 6 | \$ |
| | | | | 16 | AMOUNT TO USE FOR RATE CALCULATION | \$ |

| | |
|------------------------------|--|
| Unpaid 1998 -- 42,417 | |
| Unpaid 1999 -- 43,877 | |

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

A.

Square Feet:

29,800

B.

General Construction Type:

Exterior

BRICK

Frame

CONCRETE /STUCC

Number of Stories

1

C.

Does the Operating Entity?

☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D.

Does the Operating Entity?

☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
 ☐ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

| | 1 | 2 | 3 | 4 | |
|---|------------------|-------------|---------------|-----------|---|
| | Use | Square Feet | Year Acquired | Cost | |
| 1 | FACILITY GROUNDS | 162,206 | 1991 | \$ 31,400 | 1 |
| 2 | | | | | 2 |
| 3 | TOTALS | 162,206 | | \$ 31,400 | 3 |

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA

0037424

Report Period Beginning:

MAY 1, 1995 Ending: APRIL 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

| | 1 Beds* | FOR OHF USE ONLY | 2 Year Acquired | 3 Year Constructed | 4 Cost | 5 Current Book Depreciation | 6 Life in Years | 7 Straight Line Depreciation | 8 Adjustments | 9 Accumulated Depreciation | |
|----|------------|----------------------------------|-----------------------|--------------------------|--------------|-----------------------------------|-----------------------|------------------------------------|------------------|----------------------------------|----|
| 4 | 98 | | 1991 | 1963 | \$ 2,033,543 | \$ 47,551 | 40 | \$ 47,551 | \$ | \$ 424,272 | 4 |
| 5 | | | 1992 | 1992 | 846,649 | 21,116 | 40 | 21,116 | | 158,682 | 5 |
| 6 | | | | | | | | | | | 6 |
| 7 | | | | | | | | | | | 7 |
| 8 | | | | | | | | | | | 8 |
| | | Improvement Type** | | | | | | | | | |
| 9 | | CAPTIAL INTEREST | | 1992 | 4,384 | 110 | 40 | 110 | | 824 | 9 |
| 10 | | LIGHT FIXTURES | | 1993 | 74 | 5 | 15 | 5 | | 34 | 10 |
| 11 | | TOILET STOOLS/LAVATORIES | | 1993 | 1,757 | 117 | 15 | 117 | | 770 | 11 |
| 12 | | DOOR JAM GUARDS | | 1993 | 828 | 55 | 15 | 55 | | 363 | 12 |
| 13 | | SURVEY | | 1993 | 1,000 | 26 | 38 | 26 | | 170 | 13 |
| 14 | | McDANIEL MISC. PROJECTS | | 1993 | 2,000 | 133 | 15 | 133 | | 866 | 14 |
| 15 | | FRONT AND REAR GUTTERS | | 1993 | 3,325 | 221 | 15 | 221 | | 1,441 | 15 |
| 16 | | PLUMBING VALVE REPAIRS | | 1994 | 703 | 47 | 15 | 47 | | 298 | 16 |
| 17 | | HUD LEGAL AND HUD SURVEY | | 1994 | 38,516 | 1,015 | 40 | 1,015 | | 5,909 | 17 |
| 18 | | TILE REPAIRS | | 1994 | 458 | 11 | 40 | 11 | | 69 | 18 |
| 19 | | CONSTRUCTION MATERIALS | | 1994 | 484 | 12 | 40 | 12 | | 76 | 19 |
| 20 | | SURVEYOR & CONSTRUCTION DRAWINGS | | 1994 | 39,576 | 989 | 40 | 989 | | 6,019 | 20 |
| 21 | | STORAGE TANK REPAIRS | | 1999 | 1,315 | 73 | 3 | 73 | | 146 | 21 |
| 22 | | AIR CONDITIONING REPAIRS | | 1998 | 1,147 | 287 | 3 | 287 | | 574 | 22 |
| 23 | | REPLACE WIRING & MOLDING | | 1997 | 11,324 | 1,132 | 10 | 1,132 | | 3,727 | 23 |
| 24 | | RE-ROUTE WATER LINES | | 1994 | 650 | 16 | 40 | 16 | | 97 | 24 |
| 25 | | WET INSULATION & DECK | | 1994 | 2,598 | 104 | 25 | 104 | | 607 | 25 |
| 26 | | LAUNDRY LINT TRAP | | 1995 | 1,172 | 234 | 5 | 234 | | 1,035 | 26 |
| 27 | | ELECTRICAL WORK | | 1997 | 7,256 | 726 | 10 | 726 | | 2,213 | 27 |
| 28 | | LEASEHOLD IMPROVEMENTS 1999-2000 | | 1999 | 5,591 | 1,251 | 4 | 1,251 | | 1,251 | 28 |
| 29 | | | | | | | | | | | 29 |
| 30 | | | | | | | | | | | 30 |
| 31 | | | | | | | | | | | 31 |
| 32 | | | | | | | | | | | 32 |
| 33 | | | | | | | | | | | 33 |
| 34 | | | | | | | | | | | 34 |
| 35 | | | | | | | | | | | 35 |
| 36 | | TOTAL (lines 4 thru 35) | | | \$ 3,004,350 | \$ 75,231 | | \$ 75,231 | \$ | \$ 609,443 | 36 |

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

| | Category of Equipment | 1 Cost | Current Book Depreciation 2 | Straight Line Depreciation 3 | 4 Adjustments | Component Life 5 | Accumulated Depreciation 6 | |
|----|--------------------------|------------|-----------------------------|------------------------------|------------------|------------------|----------------------------|----|
| 37 | Purchased in Prior Years | \$ 671,390 | \$ 50,605 | \$ 50,605 | | Various | \$ 394,313 | 37 |
| 38 | Current Year Purchases | | | | | | | 38 |
| 39 | Fully Depreciated Assets | 845 | | | | 3 | 845 | 39 |
| 40 | Corporate Allocation | | 4,511 | 4,511 | | | | 40 |
| 41 | TOTALS | \$ 672,235 | \$ 55,116 | \$ 55,116 | \$ | | \$ 395,158 | 41 |

D. Vehicle Depreciation (See instructions.)*

| | 1 Use | Model, Make and Year 2 | Year Acquired 3 | 4 Cost | Current Book Depreciation 5 | Straight Line Depreciation 6 | 7 Adjustments | Life in Years 8 | Accumulated Depreciation 9 | |
|----|---------------|------------------------|-----------------|-----------|-----------------------------|------------------------------|------------------|-----------------|----------------------------|----|
| 42 | | | | \$ | \$ | \$ | \$ | | \$ | 42 |
| 43 | | | | | | | | | | 43 |
| 44 | | | | | | | | | | 44 |
| 45 | | | | | | | | | | 45 |
| 46 | TOTALS | | | \$ | \$ | \$ | \$ | | \$ | 46 |

E. Summary of Care-Related Assets

| | 1 Reference | 2 Amount | |
|----|--|--------------|-------|
| 47 | Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4) | \$ 3,707,985 | 47 |
| 48 | Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5) | \$ 130,347 | 48 |
| 49 | Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6) | \$ 130,347 | 49 ** |
| 50 | Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7) | \$ | 50 |
| 51 | Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9) | \$ 1,004,601 | 51 |

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

| | 1 Description & Year Acquired | 2 Cost | Current Book Depreciation 3 | Accumulated Depreciation 4 | |
|----|----------------------------------|-----------|-----------------------------|----------------------------|----|
| 52 | | \$ | \$ | \$ | 52 |
| 53 | | | | | 53 |
| 54 | | | | | 54 |
| 55 | | | | | 55 |
| 56 | | | | | 56 |
| 57 | TOTALS | \$ | \$ | \$ | 57 |

G. Construction-in-Progress

| | Description | Cost | |
|----|-------------|------|----|
| 58 | | \$ | 58 |
| 59 | | | 59 |
| 60 | | | 60 |
| 61 | | \$ | 61 |

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **Fireside L/P Hunter Care Center**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

| | | 1 Year Constructed | 2 Number of Beds | 3 Date of Lease | 4 Rental Amount | 5 Total Years of Lease | 6 Total Years Renewal Option* | |
|---|--------------------|--------------------------|------------------------|-----------------------|-----------------------|------------------------------|-------------------------------------|---|
| 3 | Original Building: | 1963 | 98 | | \$ 31,239 | | | 3 |
| 4 | Additions | 1992 | | | | | | 4 |
| 5 | | | | | | | | 5 |
| 6 | | | | | | | | 6 |
| 7 | TOTAL | | 98 | | \$ 31,239 | | | 7 |

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 2,865

Description:

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$

13. /2002 \$

14. /2003 \$

C. Vehicle Rental (See instructions.)

| | 1 Use | 2 Model Year and Make | 3 Monthly Lease Payment | 4 Rental Expense for this Period | |
|----|----------|-----------------------------|-------------------------------|--|----|
| 17 | | | \$ | \$ | 17 |
| 18 | | | | | 18 |
| 19 | | | | | 19 |
| 20 | | | | | 20 |
| 21 | TOTAL | | \$ | \$ | 21 |

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

| | | |
|---|---|---|
| 1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary. | 2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE <u>104</u> | 3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <u>X-FRIENDSHIP</u> HOURS PER AIDE <u>53</u> |
|---|---|---|

B. EXPENSES

ALLOCATION OF COSTS (d)

| | | 1 | 2 | 3 | 4 |
|----|---------------------------------|-----------|-----------|----------|-----------|
| | | Facility | | | |
| | | Drop-outs | Completed | Contract | Total |
| 1 | Community College Tuition | \$ | | \$ | |
| 2 | Books and Supplies | | 440 | | 1,080 |
| 3 | Classroom Wages (a) | | 3,481 | | 12,196 |
| 4 | Clinical Wages (b) | | 1,129 | | 5,644 |
| 5 | In-House Trainer Wages (c) | | | | |
| 6 | Transportation | | | | |
| 7 | Contractual Payments | | | | |
| 8 | Nurse Aide Competency Tests | | | 800 | 800 |
| 9 | TOTALS | \$ 5,050 | \$ 14,670 | \$ | \$ 19,720 |
| 10 | SUM OF line 9, col. 1 and 2 (e) | \$ 19,720 | | | |

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

| | |
|------------------------------|-----------|
| COMPLETED | |
| 1. From this facility | 16 |
| 2. From other facilities (f) | |
| DROP-OUTS | |
| 1. From this facility | 11 |
| 2. From other facilities (f) | |
| TOTAL TRAINED | 27 |

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |
|----|--|--|---------------------|------|---|------------|--------------------------------------|-------------------------------|--------------------------------|----|
| | Service | Schedule V Line & Column Reference | Staff | | Outside Practitioner (other than consultant) | | Supplies (Actual or Allocated) | Total Units (Column 2 + 4) | Total Cost (Col. 3 + 5 + 6) | |
| | | | Units of Service | Cost | Units | Cost | | | | |
| | | | | | | | | | | |
| 1 | Licensed Occupational Therapist | 10A-3 | hrs | \$ | 1,843 | \$ 73,240 | \$ 1,770 | 1,843 | \$ 75,010 | 1 |
| 2 | Licensed Speech and Language Development Therapist | 10A-3 | hrs | | 1,055 | 53,684 | 43 | 1,055 | 53,727 | 2 |
| 3 | Licensed Recreational Therapist | | hrs | | | | | | | 3 |
| 4 | Licensed Physical Therapist | 10A-3 | hrs | | 2,552 | 111,913 | 517 | 2,552 | 112,430 | 4 |
| 5 | Physician Care | | visits | | | | | | | 5 |
| 6 | Dental Care | | visits | | | | | | | 6 |
| 7 | Work Related Program | | hrs | | | | | | | 7 |
| 8 | Habilitation | | hrs | | | | | | | 8 |
| 9 | Pharmacy | 10-3 | # of prescripts | | | | | | | 9 |
| | Psychological Services (Evaluation and Diagnosis/ Behavior Modification) | | hrs | | | | | | | 10 |
| 11 | Academic Education | | hrs | | | | | | | 11 |
| 12 | Exceptional Care Program | | | | | | | | | 12 |
| 13 | Other (specify): | | | | | | | | | 13 |
| 14 | TOTAL | | | \$ | 5,449 | \$ 238,837 | \$ 2,330 | 5,449 | \$ 241,167 | 14 |

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

| | | 1 Operating | 2 After Consolidation* | |
|----|---|----------------|------------------------------|----|
| | A. Current Assets | | | |
| 1 | Cash on Hand and in Banks | \$ 2,262,713 | \$ (6,823,884) | 1 |
| 2 | Cash-Patient Deposits | | | 2 |
| 3 | Accounts & Short-Term Notes Receivable- Patients (less allowance) | 526,755 | 832,919 | 3 |
| 4 | Supply Inventory (priced at <u>COST</u>) | 2,813 | | 4 |
| 5 | Short-Term Investments | | | 5 |
| 6 | Prepaid Insurance | | 535,882 | 6 |
| 7 | Other Prepaid Expenses | 31,733 | 86,192 | 7 |
| 8 | Accounts Receivable (owners or related parties) | | | 8 |
| 9 | Other(specify): <u>Escrow/Rent Rec</u> | 77,063 | | 9 |
| 10 | TOTAL Current Assets (sum of lines 1 thru 9) | \$ 2,901,077 | \$ (5,368,891) | 10 |
| | B. Long-Term Assets | | | |
| 11 | Long-Term Notes Receivable | 297,821 | | 11 |
| 12 | Long-Term Investments | | 95,010 | 12 |
| 13 | Land | 31,400 | | 13 |
| 14 | Buildings, at Historical Cost | 2,996,968 | | 14 |
| 15 | Leasehold Improvements, at Historical Cost | 5,591 | 70,492 | 15 |
| 16 | Equipment, at Historical Cost | 674,026 | 852,291 | 16 |
| 17 | Accumulated Depreciation (book methods) | (1,004,601) | (484,221) | 17 |
| 18 | Deferred Charges | | 792,224 | 18 |
| 19 | Organization & Pre-Operating Costs | | 1,272,017 | 19 |
| 20 | Accumulated Amortization - Organization & Pre-Operating Costs | | | 20 |
| 21 | Restricted Funds | | | 21 |
| 22 | Other Long-Term Assets (specify: <u>Construction Cost</u>) | 99,995 | 14,665 | 22 |
| 23 | Other(specify): <u>Replacement Reserve</u> | 162,455 | 26,657,125 | 23 |
| 24 | TOTAL Long-Term Assets (sum of lines 11 thru 23) | \$ 3,263,655 | \$ 29,269,603 | 24 |
| 25 | TOTAL ASSETS (sum of lines 10 and 24) | \$ 6,164,732 | \$ 23,900,712 | 25 |

| | | 1 Operating | 2 After Consolidation* | |
|----|---|----------------|------------------------------|----|
| | C. Current Liabilities | | | |
| 26 | Accounts Payable | \$ 394,043 | \$ 2,206,164 | 26 |
| 27 | Officer's Accounts Payable | | | 27 |
| 28 | Accounts Payable-Patient Deposits | 1,801 | | 28 |
| 29 | Short-Term Notes Payable | | | 29 |
| 30 | Accrued Salaries Payable | 73,882 | 1,680,718 | 30 |
| 31 | Accrued Taxes Payable (excluding real estate taxes) | | | 31 |
| 32 | Accrued Real Estate Taxes(Sch.IX-B) | 56,039 | 325 | 32 |
| 33 | Accrued Interest Payable | | 397,943 | 33 |
| 34 | Deferred Compensation | | 325,552 | 34 |
| 35 | Federal and State Income Taxes | | 13,400 | 35 |
| | Other Current Liabilities(specify): | | | |
| 36 | <u>Rent Payable/Deferred Rent income</u> | 54,214 | 56,678 | 36 |
| 37 | <u>Accr Acct/State Assessment</u> | 10,885 | 970 | 37 |
| 38 | TOTAL Current Liabilities (sum of lines 26 thru 37) | \$ 590,864 | \$ 4,681,750 | 38 |
| | D. Long-Term Liabilities | | | |
| 39 | Long-Term Notes Payable | 297,821 | 17,715,325 | 39 |
| 40 | Mortgage Payable | 2,843,767 | | 40 |
| 41 | Bonds Payable | | | 41 |
| 42 | Deferred Compensation | | | 42 |
| | Other Long-Term Liabilities(specify): | | | |
| 43 | <u>Intercompany</u> | 2,248,197 | | 43 |
| 44 | | | | 44 |
| 45 | TOTAL Long-Term Liabilities (sum of lines 39 thru 44) | \$ 5,389,785 | \$ 17,715,325 | 45 |
| 46 | TOTAL LIABILITIES (sum of lines 38 and 45) | \$ 5,980,649 | \$ 22,397,075 | 46 |
| 47 | TOTAL EQUITY (page 18, line 24) | \$ 184,083 | \$ 1,503,637 | 47 |
| 48 | TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47) | \$ 6,164,732 | \$ 23,900,712 | 48 |

*(See instructions.)

| | | 1 Total | |
|----|--|-------------|------|
| 1 | Balance at Beginning of Year, as Previously Reported | \$ 114,787 | 1 |
| 2 | Restatements (describe): | | 2 |
| 3 | Net Income Adjustment for 1999 | (181,132) | 3 |
| 4 | | | 4 |
| 5 | | | 5 |
| 6 | Balance at Beginning of Year, as Restated (sum of lines 1-5) | \$ (66,345) | 6 |
| | A. Additions (deductions): | | |
| 7 | NET Income (Loss) (from page 19, line 43) | 167,751 | 7 |
| 8 | Aquisitions of Pooled Companies | | 8 |
| 9 | Proceeds from Sale of Stock | | 9 |
| 10 | Stock Options Exercised | | 10 |
| 11 | Contributions and Grants | | 11 |
| 12 | Expenditures for Specific Purposes | | 12 |
| 13 | Dividends Paid or Other Distributions to Owners | () | 13 |
| 14 | Donated Property, Plant, and Equipment | | 14 |
| 15 | Other (describe) Rounding | (74) | 15 |
| 16 | Other (describe) | | 16 |
| 17 | TOTAL Additions (deductions) (sum of lines 7-16) | \$ 167,677 | 17 |
| | B. Transfers (Itemize): | | |
| 18 | Firesidep L/P Property Ledger Net Income | 82,751 | 18 |
| 19 | | | 19 |
| 20 | | | 20 |
| 21 | | | 21 |
| 22 | | | 22 |
| 23 | TOTAL Transfers (sum of lines 18-22) | \$ 82,751 | 23 |
| 24 | BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23) | \$ 184,083 | 24 * |

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

| 1 | | | |
|-----|---|--------------|-----|
| | Revenue | Amount | |
| | A. Inpatient Care | | |
| 1 | Gross Revenue -- All Levels of Care | \$ 3,204,344 | 1 |
| 2 | Discounts and Allowances for all Levels | (130,319) | 2 |
| 3 | SUBTOTAL Inpatient Care (line 1 minus line 2) | \$ 3,074,025 | 3 |
| | B. Ancillary Revenue | | |
| 4 | Day Care | | 4 |
| 5 | Other Care for Outpatients | | 5 |
| 6 | Therapy | 127,417 | 6 |
| 7 | Oxygen | 1 | 7 |
| 8 | SUBTOTAL Ancillary Revenue (lines 4 thru 7) | \$ 127,418 | 8 |
| | C. Other Operating Revenue | | |
| 9 | Payments for Education | | 9 |
| 10 | Other Government Grants | | 10 |
| 11 | Nurses Aide Training Reimbursements | | 11 |
| 12 | Gift and Coffee Shop | 1,116 | 12 |
| 13 | Barber and Beauty Care | | 13 |
| 14 | Non-Patient Meals | 306 | 14 |
| 15 | Telephone, Television and Radio | 325 | 15 |
| 16 | Rental of Facility Space | | 16 |
| 17 | Sale of Drugs | | 17 |
| 18 | Sale of Supplies to Non-Patients | | 18 |
| 19 | Laboratory | 16 | 19 |
| 20 | Radiology and X-Ray | | 20 |
| 21 | Other Medical Services | 4,755 | 21 |
| 22 | Laundry | | 22 |
| 23 | SUBTOTAL Other Operating Revenue (lines 9 thru 22) | \$ 6,518 | 23 |
| | D. Non-Operating Revenue | | |
| 24 | Contributions | | 24 |
| 25 | Interest and Other Investment Income*** | 19 | 25 |
| 26 | SUBTOTAL Non-Operating Revenue (lines 24 and 25) | \$ 19 | 26 |
| | E. Other Revenue (specify):**** | | |
| 27 | Settlement Income (Insurance, Legal, Etc.) | | 27 |
| 28 | HPSI Fees | 422 | 28 |
| 28a | | | 28a |
| 29 | SUBTOTAL Other Revenue (lines 27, 28 and 28a) | \$ 422 | 29 |
| 30 | TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29) | \$ 3,208,402 | 30 |

| 2 | | | |
|----|--|--------------|----|
| | Expenses | Amount | |
| | A. Operating Expenses | | |
| 31 | General Services | 516,223 | 31 |
| 32 | Health Care | 1,155,993 | 32 |
| 33 | General Administration | 785,652 | 33 |
| | B. Capital Expense | | |
| 34 | Ownership | 413,898 | 34 |
| | C. Ancillary Expense | | |
| 35 | Special Cost Centers | 115,230 | 35 |
| 36 | Provider Participation Fee | 53,655 | 36 |
| | D. Other Expenses (specify): | | |
| 37 | | | 37 |
| 38 | | | 38 |
| 39 | | | 39 |
| 40 | TOTAL EXPENSES (sum of lines 31 thru 39)* | \$ 3,040,651 | 40 |
| 41 | Income before Income Taxes (line 30 minus line 40)** | 167,751 | 41 |
| 42 | Income Taxes | | 42 |
| 43 | NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42) | \$ 167,751 | 43 |

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **FIRESIDE HOUSE OF CENTRALIA**# **0037424**Report Period Beginning: **MAY 1, 1999**

Ending:

APRIL 30, 2000**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

| | | 1 | 2** | 3 | 4 | |
|----|-------------------------------|---------------------------------|----------------------------------|--|---------------------------|----|
| | | # of Hrs. Actually Worked | # of Hrs. Paid and Accrued | Reporting Period Total Salaries, Wages | Average Hourly Wage | |
| 1 | Director of Nursing | 1,833 | 1,890 | \$ 36,681 | \$ 19.41 | 1 |
| 2 | Assistant Director of Nursing | | | | | 2 |
| 3 | Registered Nurses | 15,604 | 16,091 | 219,916 | 13.67 | 3 |
| 4 | Licensed Practical Nurses | 9,367 | 9,660 | 102,107 | 10.57 | 4 |
| 5 | Nurse Aides & Orderlies | 51,405 | 53,013 | 354,833 | 6.69 | 5 |
| 6 | Nurse Aide Trainees | 1,537 | 1,585 | 10,605 | 6.69 | 6 |
| 7 | Licensed Therapist | | | | | 7 |
| 8 | Rehab/Therapy Aides | 1,897 | 1,952 | 15,301 | 7.84 | 8 |
| 9 | Activity Director | | | | | 9 |
| 10 | Activity Assistants | 3,377 | 3,505 | 23,580 | 6.73 | 10 |
| 11 | Social Service Workers | 1,871 | 1,925 | 16,442 | 8.54 | 11 |
| 12 | Dietician | | | | | 12 |
| 13 | Food Service Supervisor | | | | | 13 |
| 14 | Head Cook | | | | | 14 |
| 15 | Cook Helpers/Assistants | 16,532 | 17,201 | 108,252 | 6.29 | 15 |
| 16 | Dishwashers | | | | | 16 |
| 17 | Maintenance Workers | 2,004 | 2,052 | 19,353 | 9.43 | 17 |
| 18 | Housekeepers | 11,474 | 11,944 | 65,852 | 5.51 | 18 |
| 19 | Laundry | 5,752 | 5,967 | 33,691 | 5.65 | 19 |
| 20 | Administrator | 2,027 | 2,074 | 44,657 | 21.53 | 20 |
| 21 | Assistant Administrator | | | | | 21 |
| 22 | Other Administrative | | | | | 22 |
| 23 | Office Manager | | | | | 23 |
| 24 | Clerical | 1,989 | 2,035 | 17,049 | 8.38 | 24 |
| 25 | Vocational Instruction | | | | | 25 |
| 26 | Academic Instruction | | | | | 26 |
| 27 | Medical Director | | | | | 27 |
| 28 | Qualified MR Prof. (QMRP) | | | | | 28 |
| 29 | Resident Services Coordinator | | | | | 29 |
| 30 | Habilitation Aides (DD Homes) | | | | | 30 |
| 31 | Medical Records | 4,991 | 5,106 | 38,400 | 7.52 | 31 |
| 32 | Other Health Care(specify) | | | | | 32 |
| 33 | Other(specify) | | | | | 33 |
| 34 | TOTAL (lines 1 - 33) | 131,660 | 136,000 | \$ 1,106,719 * | \$ 8.14 | 34 |

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

| | | 1 | 2 | 3 | |
|----|--|--|---|---|----|
| | | Number of Hrs. Paid & Accrued | Total Consultant Cost for Reporting Period | Schedule V Line & Column Reference | |
| 35 | Dietary Consultant | 186 | \$ 7,420 | | 35 |
| 36 | Medical Director | 80 | 4,800 | | 36 |
| 37 | Medical Records Consultant | 132 | 6,575 | | 37 |
| 38 | Nurse Consultant | 1,823 | 51,348 | | 38 |
| 39 | Pharmacist Consultant | 62 | 2,158 | | 39 |
| 40 | Physical Therapy Consultant | | | | 40 |
| 41 | Occupational Therapy Consultant | | | | 41 |
| 42 | Respiratory Therapy Consultant | | | | 42 |
| 43 | Speech Therapy Consultant | | | | 43 |
| 44 | Activity Consultant | 47 | 2,331 | | 44 |
| 45 | Social Service Consultant | 44 | 2,192 | | 45 |
| 46 | Other(specify) <u>Medicare Coordinator</u> | | 5,808 | | 46 |
| 47 | <u>Reimbursement Consultant</u> | 49 | 4,887 | | 47 |
| 48 | | | | | 48 |
| 49 | TOTAL (lines 35 - 48) | 2,423 | \$ 87,519 | | 49 |

C. CONTRACT NURSES

| | | 1 | 2 | 3 | |
|----|---------------------------|--|----------------------------|---|----|
| | | Number of Hrs. Paid & Accrued | Total Contract Wages | Schedule V Line & Column Reference | |
| 50 | Registered Nurses | | \$ | | 50 |
| 51 | Licensed Practical Nurses | | | | 51 |
| 52 | Nurse Aides | | | | 52 |
| 53 | TOTAL (lines 50 - 52) | | \$ | | 53 |

| | | | | | | | | |
|---|--|--|--|---|--|--|---|--|
| A. Administrative Salaries Name Function Ownership % Amount Dave Eifert Administrator 0 \$ 44,657 | | | | D. Employee Benefits and Payroll Taxes Description Amount Workers' Compensation Insurance \$ 60,074 Unemployment Compensation Insurance 22,347 FICA Taxes 84,044 Employee Health Insurance 23,099 Employee Meals _____ Illinois Municipal Retirement Fund (IMRF)* _____ Employee Physicals 3,000 Employee Vaccinations 2,212 Other Employee Benefits 2,740 | | | F. Dues, Fees, Subscriptions and Promotions Description Amount IDPH License Fee \$ 536 Advertising: Employee Recruitment 3,606 Health Care Worker Background Check 442 (Indicate # of checks performed 44) _____ HPSI Fees 496 Illinois HealthCare Association 4,042 Marketing Advertising 4,698 Misc. Due and Fees 1,774 Corporate Allocation 654 _____ Less: Public Relations Expense (422) Non-allowable advertising (4,698) Yellow page advertising () TOTAL (agree to Sch. V, line 20, col. 8) \$ 11,128 | |
| TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.) \$ 44,657 | | | | _____ _____ Corporate Office Allocation 14,743 _____ TOTAL (agree to Schedule V, line 22, col.8) \$ 212,259 | | | | |
| B. Administrative - Other Description Amount Management Fees \$ 189,285 Acct. Office Allocation 67,061 Corporate Office Alloc 157,465 Regional Office Alloc 49,919 TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement) \$ 463,730 | | | | E. Schedule of Non-Cash Compensation Paid to Owners or Employees Description Line # Amount _____ _____ \$ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ TOTAL \$ _____ | | | G. Schedule of Travel and Seminar** Description Amount Out-of-State Travel \$ _____ _____ Corporate Allocation 18,529 In-State Travel 1,919 Meals 222 Lodging 292 _____ Seminar Expense 756 _____ _____ Entertainment Expense () (agree to Sch. V, line 24, col. 8) TOTAL \$ 21,718 | |
| C. Professional Services Vendor/Payee Type Amount _____ Legal \$ 429 _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.) \$ 429 | | | | | | | | |

* Attach copy of IMRF notifications

**See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)**

[illegible]

Facility Name & ID Number **FIRESIDE HOUSE OF CENTRALIA**

STATE OF ILLINOIS

0037424

Report Period Beginning: **MAY 1, 1999** Ending: **APRIL 30, 2000**

Page 23

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Illinois Health Care 4042
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5-15
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,618 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 53,655
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ _____ Has any meal income been offset against related costs? YES Indicate the amount. \$ 306
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.